Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3761-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "Denial by T. Mutual."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $767.67

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "1. The claimant is seeking reimbursement for medications by by him for most of 2009 and to date in 2010. 2. Texas Mutual has received no clinical or medical information from the prescribing physician or any other health care provider since May 2008. 3. Texas Mutual requested documentation in March 2010 from the prescribing physician Dr. William Bond, M.D. No response from Dr. Bond has been received. Because there has been no documented clinical basis made available to Texas Mutual to justify the need for the medications Texas Mutual declined to issue payment. 4. Because the EOBs indicate medical necessity was the reason for denial, medical fee dispute resolution is not the proper venue for this dispute…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
05/14/2009 – 05/07/2010	No EOBs (EOB submitted was sent to CVS)	Out-of-Pocket Expenses for prescriptions – CVS Pharmacy	$236.33	$0.00
09/16/2009 – 05/07/2010	No EOBs (EOB submitted was sent to Medstar)	Out-of-Pocket Expenses for prescriptions – Medstar Pharmacy	$905.03	$0.00
04/24/2009 – 06/30/2009	No EOBs (EOB submitted was sent to Walgreens)	Out-of-Pocket Expenses for prescriptions – Walgreens Pharmacy	$122.18	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution received the request for medical dispute resolution on April 26, 2010. Dates of service 02/12/2009, 02/17/2009, 03/13/2009 and 04/05/2009 were not filed within the one-year filing time as required by 28 Texas Admin Code Section §133.307(c)(1); therefore, these dates of service will not be reviewed.

2. This dispute relates to out-of-pocket expenses with reimbursement subject to the provisions of 28 Texas Admin Code Section §133.270 and §134.504.

3. The Insurance Carrier's response indicates that the disputed dates of service were denied reimbursement for medical necessity. According to the Carrier, a request for documentation was made in March 2010 to the prescribing physician Dr. William Bond, M.D.; however, they did not receive a response.

4. According to 28 Texas Admin Code Section §133.305, Medical Fee Dispute Resolution does not have the authority to review disputes with issues of medical necessity.

5. Pursuant the 28 Texas Admin Code Section §133.307(e)(3)(G) the Division concludes that this dispute was submitted to the incorrect venue. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.305, §133.307, §133.308 and §134.504

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		June 25, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.